Department of Behavioral Healthcare, Developmental Disabilities & Hospitals

BHDDH Today

March, 2012

Today, BHDDH looks back on a year of significant and positive changes that have occurred as a result of the Department's continuing efforts to provide those with behavioral health and substance use issues, developmental disabilities, and long-term medical and psychiatric conditions access to quality services and supports. A number of important initiatives have been achieved in fiscal year 2012.

A State plan amendment for Medicaid Health Homes, approved by the Centers for Medicare and Medicaid Services (CMS), provides BHDDH with enhanced federal funding to coordinate physical care and behavioral healthcare for individuals who have serious and persistent mental health conditions. Rhode Island is the first state in the country to address coordinated care for individuals with serious mental illness and to discuss peer supports in a health homes state plan amendment. The Department anticipates that, as a result of Health Homes care coordination, emergency room and inpatient hospitalizations for this population will be reduced.

We are continuing to change the structure of our developmental disabilities system of care. Phase 2 of the transformation has been completed. This includes administering the Supports Intensity Scale (SIS) for over 800 individuals with developmental disabilities.

The provision of excellent, high-quality patient care remains a priority for Eleanor Slater Hospital as it looks to FY 2013 and beyond. On March 3, 2012 Director Stenning was presented with proclamations from the Rhode Island Senate, House of Representatives and Lt. Governor Elizabeth Roberts because of the excellent report that The Joint Commission (TJC) gave the Eleanor Slater Hospital as a result of the recent TJC survey. The surveyors from the Commission commented on the commitment, compassion and dedication of the Eleanor Slater Hospital employees to improving patients' quality of life.

Division of Developmental Disabilities

This year saw the completion of Phase 2 of our major transformation of the system of care for individuals with developmental disabilities. Phase 2 consisted of further defining services, developing rate methodologies for each of the services, and administering the Supports Intensity Scale (SIS) for over 800 individuals. The new service definitions and rate methodologies for July 1, 2011, October 1, 2011 and January 1, 2012 have all been approved by CMS.

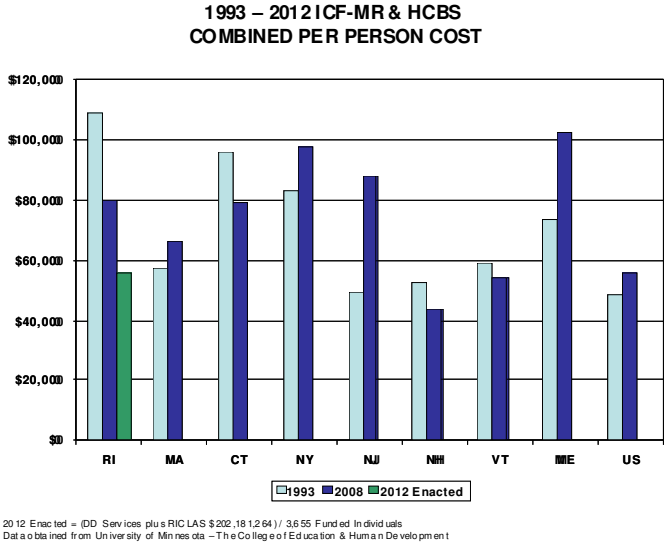
Although it has been difficult to implement the new rates, given the reduction of funding, it is important to note that all eligible individuals were given service authorizations at or above previous levels. New transportation rates were established, and transportation was authorized for all individuals requiring and requesting this service. We continue to authorize day programs and community-based supports, and we have made the system more flexible so that individuals may choose to spend more time in the community and less time at their day programs or vice versa.

The SIS (Support Intensity Scale) is a standardized assessment tool designed by the American Association on Intellectual and Developmental Disabilities (AAIDD) to measure the pattern and intensity of supports an adult with a developmental disability requires to be successful in a community setting. The tool is administered by a certified SIS worker and is administered with two or more respondents who know the person well. This may include a parent, sibling, spouse/significant other, friend, neighbor, roommate, employer, or other family members. Other possible respondents may be a member of the direct support professional staff, a support coordinator or another provider. From September, 2011 to date, the Department has administered more than 813 SIS.

Similar to past years, the Developmental Disability (DD) Service system consists of 42 licensed providers. 41 are privately operated, and one is a publicly operated provider: Rhode Island Community Living and Supports (RICLAS).

This Division administers a system of support to approximately 3,600 individuals with developmental disabilities. Individuals who receive services are from 38 of the state's 39 cities and towns, and eligibility determinations for DD services are handled by the Department's eligibility unit. From July 1, 2010 to June 30, 2011, 247 applications were processed through the eligibility unit. Nineteen (19) percent of those applications reviewed were found to be ineligible for DD services.

Based on the FY 2012 enacted budget, the average per person cost for DD services in RI is $55,316. This is a 31% decline from FY 2008.



The Quality Improvement Unit at BHDDH is charged with assuring the safety of individuals with developmental disabilities supported by the Department, and adults with chronic disabilities residing in the community. The Unit operates a 24/7 hotline, taking reports and providing assistance for all developmentally disabled adults, adults between 18 and 60 who are chronically disabled or who are mentally disabled. The Unit investigates reports and conducts ongoing analyses of reports. Based upon the analysis of the reporting, we identify problem areas and conduct extensive training and policy reviews with providers and other stakeholders. The Unit also conducts quality reviews of licensed agencies providing supports to adults with developmental disabilities.

Just since July of last year, QI has received 1,305 calls on the hotline, which is an increasing trend. Some of this is due to the Department's recent training initiatives on serious reportable incidents and outreach to the community. However, the majority of the calls are related to emergency room visits and unanticipated hospitalizations.

QI has also been handling complaints from family members and individuals regarding alleged reduction in services to participants in the DD system. Each of these alleged reductions in service were handled and fully investigated by QI staff. None of them were founded and QI staff assisted the family and/or participant in advocating for the services they were entitled to under their ISP and quarterly authorization. In many instances, families had been scared by the publicity surrounding the implementation of Project Sustainability and/or the reduction in the FY 2012 DD appropriations. At the start of the fiscal year, families were being told that transportation was no longer being covered. QI handled many of these cases, where families were terrified and misinformed regarding the availability of transportation to and from Medicaid programs. In every one of these cases, QI was able to work with the family or participants to ensure that the transportation funding was honored.

In addition, many of the investigations concerning quarterly authorizations have involved QI advocating for a participant to receive services in line with the system expectations and the health and safety minimum standards contained in the Regulations. Invariably, service shortfalls resulted from the provider billing for services at an unnecessarily high staff ratio and/or not providing supports at the prescribed staff ratio according to the level of services indicated for a particular participant. QI is also focusing on the use of unauthorized restraint and/or the development of care plans that have positive reinforcements as well as plans that reduce the likelihood of restraint being needed and/or contain restrictive procedures that staff are fully trained, so as to reduce the likelihood of injury and maintain the health, safety and dignity of developmentally disabled adults living in the community.

Eleanor Slater Hospital

The Eleanor Slater Hospital (ESH) operates on two campuses (Cranston and Burrillville). The Hospital provides long-term acute and post-acute levels of care to patients with some complex medical and psychiatric needs who cannot be cared for anywhere else. We continue to improve our patient care processes and operations, when based on sound indicators, through collaboration among the Hospital's leadership, physicians, nurses, and rehabilitative staff.

ESH is surveyed every three years by The Joint Commission, a national accrediting body designated by the Centers for Medicare and Medicaid Services (CMS), to ensure quality in the delivery of care to patients in hospitals. This Accreditation is a condition of state licensure as a hospital, as well as entitlement to Medicaid and Medicare reimbursement.

The last visit by The Joint Commission was in December of 2011. At that time, three surveyors spent a total of five days conducting an in-depth survey based upon the standards developed by The Joint Commission and CMS. The results of the survey revealed a hospital program compliant with standards resulting in the continuation of the existing accreditation award with minimal Requirements for Improvement (RFI). These RFI's focused upon procedural, non-clinical areas to address, since patient care was never an area of concern. Retrospectively, these survey results rank among the best in the history of the hospital.

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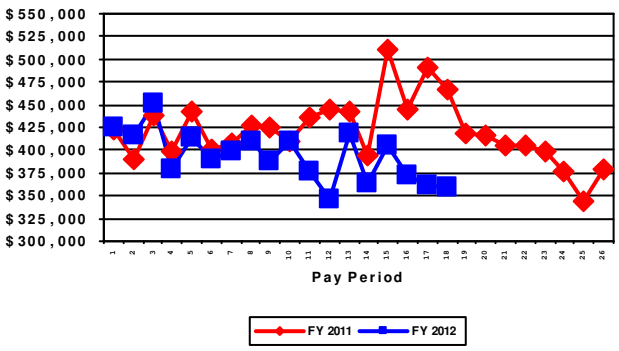
Reducing Overtime Costs at Eleanor Slater Hospital and RICLAS: A Fiscal Priority

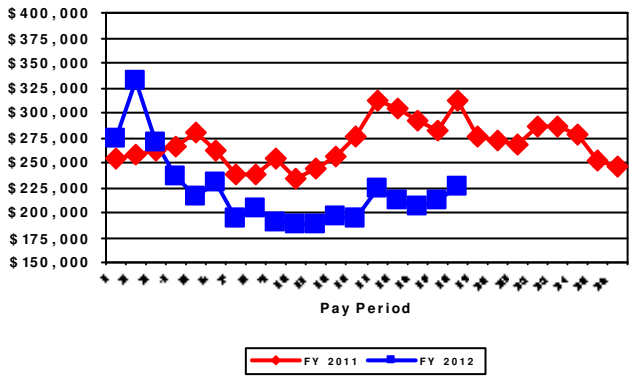
ESH is actively participating in an effort to reduce overtime through ongoing review of all overtime use and the identification of essential direct care positions that need to be filled. BHDDH has reduced expenditures in the RICLAS program through the consolidation of three group residences. As a result of the consolidation, there has been a significant reduction in overtime.

As of July 1, 2011, Eleanor Slater Hospital and RICLAS had 332 and 775.2 active FTE respectively. Since then, Eleanor Slater has hired 38 FTE and RICLAS has hired 4 FTE. In theory, Eleanor Slater should have 813.2 active FTE (775.2 plus 38). However, due to the rate of attrition, there are only 786.7 as of March 9. This is effectively a 26.5 FTE shortage.

FY 11-12 ELEANOR SLATER HOSPITAL OVERTIME ANALYSIS



FY 11-12 RICLAS OVERTIME ANALYSIS



The case is similar for RICLAS with only 314 FTE as of March 9, which is effectively short by 22 FTE. Although both Eleanor Slater and RICLAS have adopted measures to control overtime as demonstrated in the charts, overtime continues to be a challenge for the Department because the rate of attrition is greater than the hiring rate. The Department is currently working with OHHS and DOA to develop a new process of continuous recruitment for critical overtime positions such as nurses, community living aides and certified nursing aides.

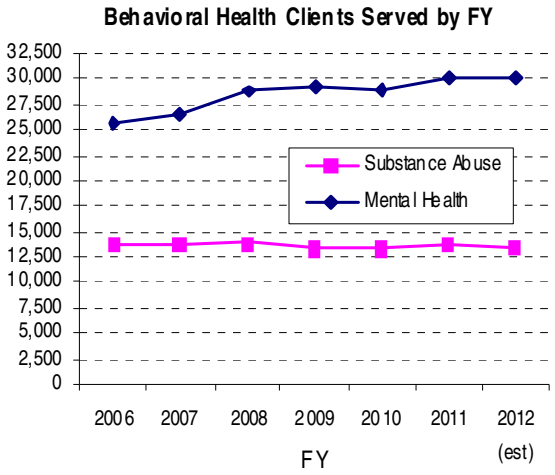
Division of Behavioral Healthcare

The Division of Behavioral Healthcare (DBH) administered a system of care that provided clinical treatment services and supports for approximately 43,700 individuals in FY 2011. The system of care consists of 104 funded community-based providers, augmented by discretionary grants from the Centers for Mental Health Services and Substance Abuse Treatment. The DBH incorporates the formerly separate divisions of Integrated Mental Health (IMH) and Substance Abuse Treatment (SAT). The Division of Behavioral Health Services is responsible for planning, coordinating, and administering comprehensive, state-wide systems of substance abuse prevention and the promotion of mental health; screening and brief intervention; early intervention and referral; substance abuse and mental illness clinical treatment services; and recovery support activities. Effective with the state fiscal year (SFY) 2011 budget, the Division consolidated the formerly separate Integrated Mental Health and Substance Abuse Treatment Services budgets.

In FY 2011, DBH served 13,599 unique individuals in the substance abuse treatment system. An additional 30,091 were served by the mental health treatment system. These systems are projected to serve 13,450 and 30,150 individuals, respectively, in FY 2012 (see chart to right).

When comparing clients served in the substance abuse system to those in the mental health system, it appears that demands for services from the mental health system continue to increase, while demands remain relatively stable for substance abuse (see chart below). However, the difference in the rates of increase for clients served in these populations actually results from differences in the funding sources for each. Individuals served in the mental health system, especially those with serious and persistent mental illness (SPMI) designations and/or those meeting community support population (CSP) criteria, typically are found eligible for Medicaid, which means that treatment is paid on a fee-for-service and per diem basis. Addictive disorders do not qualify an individual for Medicaid.

The primary funding sources for substance abuse treatment are state general revenue and federal block grant dollars. This funding allocates a finite number of slots and beds to serve individuals in all levels of care for substance abuse treatment. As unemployment rates increase, the demand for substance abuse services for the uninsured will continue to rise, but the ability to meet the demand is capped by the number of treatment slots available. This increased demand, coupled with several years of rate and budgetary pressure, have challenged the Department and the treatment system as a whole.



Community Mental Health Organizations as Health Homes

The most important initiative the Department achieved in fiscal year 2012 was the federal approval of community mental health organizations as Medicaid Health Homes. This budget initiative provided a federal Medicaid match that increased from 52.348% to 90% for eight quarters. The enhanced rate negates any financial or clinical impact to agencies that would have been affected by a sudden transformation to a per person case rate. The additional eight-quarter period allows the Department and stakeholders, working on this initiative, to implement changes to a per person case rate in a planned manner. This saves the State a considerable amount of dollars and implements a recovery-oriented, outcome-based system which will not require an infusion of new dollars. The implementation of CMHO Health Homes began on 10-1-11. Anticipated outcomes of healthcare coordination, wellness promotion, and individual/family supports include decreased use of emergency departments, decreased hospitalization, increased involvement in wellness activities and improved engagement with primary care. The funds saved as a result of Health Homes will be re-applied to the Behavioral Healthcare system once the eight quarters of the 90% federal match ends.

BHDDH also achieved the most general revenue savings under the Cost Not Otherwise Matchable (CNOM) provision of the Global Waiver. The Department has worked with providers to implement the CNOMs, which will result in over $8 million in general revenue savings this fiscal year. It is important to note that the implementation has been difficult at best. For the State, issues have arisen related to programming for claims adjudication and auditing provider agencies. For provider agencies, there are additional administrative requirements with no additional funding.

Addiction Treatment

Programs that provide services for individuals with addictive disorders are licensed, monitored and funded by BHDDH. Funding for addictions treatment is provided through the federal Substance Abuse Prevention Treatment Block Grant (SAPTBG) Block Grant, state general revenue dollars, Medicaid and other federal grants such as the Access to Recovery Program. Addiction treatment programs include the following:

Detoxification Services

BHDDH has a single contractor for statewide detoxification services. In 2011 this service, along with psychiatric hospitalization, step-down and emergency room diversion, were put out to bid. The contract was awarded to The Providence Center's RESPECT (Recover-oriented, Empathic Services Proactively Empowering Consumers in Treatment) program. The RESPECT program offers an increase in the amount of outpatient detoxification offered to opioid-dependent individuals and provides them with rapid access to decrease the demand for more expensive inpatient treatment. This program also offers detox step-down beds which provide an alternative to continued medical detoxification while an individual is stabilized for reintegration into the community or a residential treatment setting.

General Outpatient Program

The General Outpatient Program (GOP) for the indigent and uninsured continues to provide drug-free outpatient services for alcohol, drug dependent and addicted persons. Services for uninsured clients were procured again on 3/1/12, following a request for proposals developed by the Department, and the total amount of the contract for fiscal year 2012 was reduced by $200,000. The GOP continues to work with five prime contractors - organizing services in their respective service areas which encompass general outpatient, intensive outpatient and partial hospitalization levels of care. New contracts require the contracted providers to establish strong links with recovery support service providers in their communities.

Residential Services

BHDDH funds residential treatment services for adults and adolescents. The adult residential treatment system ranges from short-term (30 – 90 days) to long-term care and includes working half-way houses. Three of the adult residential providers are women-only facilities, and include a program where children are able to stay with their mothers while they are in treatment. As part of the 2013 budget proposal, BHDDH proposes to procure these services again, through the RFP process.

Opioid Treatment Programs (OTP)

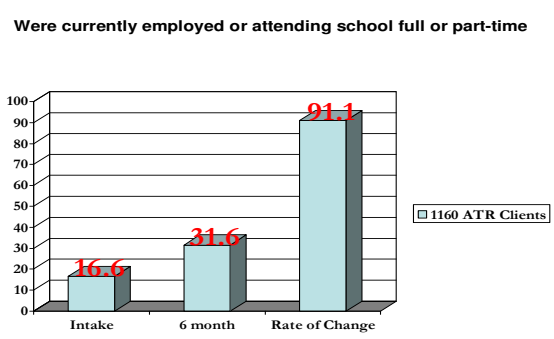
BHDDH functions as the federally-mandated State Opioid Treatment Authority. The Department funds eight of the thirteen authorized OTP programs in the State. It is anticipated that use of heroin and synthetic opioids will continue to be a significant issue in the State of Rhode Island. Because of this, these funded treatment slots will be consistently filled beyond capacity. These slots are supported by the use of CNOMS through the Global Medicaid Waiver. The 2013 budget proposal calls for the creation of Medicaid-supported Health Homes for Medicaid-funded opioid treatment clients.

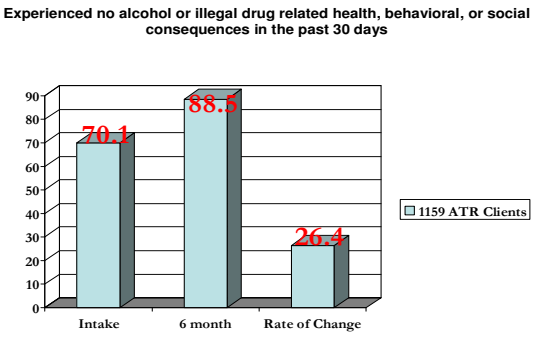
A primary focus for BHDDH is the incorporation of recovery principles into its service delivery system. Recovery-oriented systems support person-centered and self-directed approaches to care that build on the strengths and resilience of individuals, families and communities, encouraging them to take responsibility for their sustained health, wellness and recovery. BHDDH's movement in this area has been guided by the recommendations of the Governor's Council on Behavioral Healthcare, Recovery Oriented System of Care Committee. Development and enhancement of a recovery-oriented system of care (ROSC) has been furthered by the recent receipt of three grants: The Access to Recovery, the Transformation Transfer Initiative and the Employment Development Initiative.

In September of 2007 and again in September 2010, the Department was awarded an Access to Recovery grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). The Access to Recovery (ATR) allows clients to choose among substance abuse clinical treatment and recovery support service providers, expands access to a comprehensive array of clinical treatment and recovery support options (including faith-based programmatic options), and increases substance abuse treatment capacity. Since 2007, the Rhode Island ATR has served over 2600 clients, providing clinical treatment and recovery support services resulting in positive, measureable outcomes.

The ATR program has resulted in significant improvements in abstinence rates with 36.6% reporting no alcohol or drug use at 5 to 7 months after admission to the program. The program also has contributed to a significant decrease in arrest (or re-arrest) rates, 5 to 7 months post-admission.

As indicated in the charts below, there are also significant improvements in employment/education status (91.1%) and (26.4%) reducing negative consequences related to alcohol or illicit drug use (26.4%).





The rate for connecting socially improved by 6% (with overall rate reported at follow-up to be 92.6%). Stability in the housing rate improved by 102.1%.

The Department continues to implement the Transition from Prison to Community Program. This program provides residential or intensive outpatient substance abuse treatment services to parolees for whom these services are a required condition of parole. This funding has increased capacity at residential treatment programs and allowed inmates, who were previously waiting in prison for a state-funded residential bed to become available, to have quicker access to treatment. All referred parolees receive a standardized assessment by a Licensed Chemical Dependency Professional and are then referred to the appropriate clinical setting. To date, 757 assessments have been completed with 646 admissions to residential treatment and 99 Intensive Out-Patient (IOP) admissions. Six clients are awaiting placement and six refused treatment.

Additional funding for this initiative was obtained through Byrne/Jag and contracted through The Providence Center. These funds increased the overall residential beds available for this program and provided recovery support services following successful completion of treatment. While the residential portion of Byrne/Jag funding has been exhausted, the Department continues to support recovery services for this population.

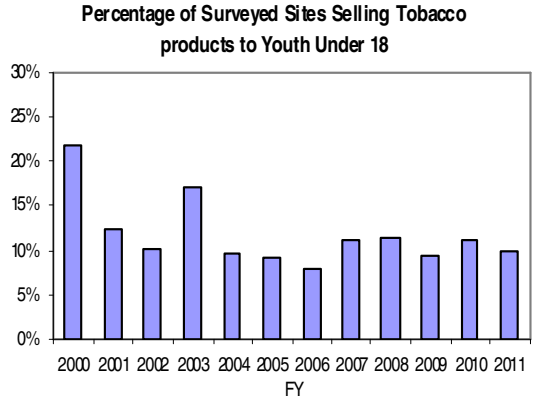
The Department implemented a number of behavioral health budget reduction initiatives in FY 2012. These initiatives included procuring the substance abuse outpatient treatment contracts again at a reduced cost; reducing funding for adolescent residential substance abuse treatment requiring providers to seek funding from third party payers, including commercial carriers; and reducing funding available for substance abuse detoxification services as described in sections above. Other budget initiatives included restricting eligibility for the Community Medication Assistance Program (CMAP) and consolidating two behavioral healthcare provider training contracts. In previous years, the Department has modified payments, reduced contracts, and implemented length-of-stay and fee-for-service requirements, among others, in efforts to attain targeted budget reduction requirements.

Prevention

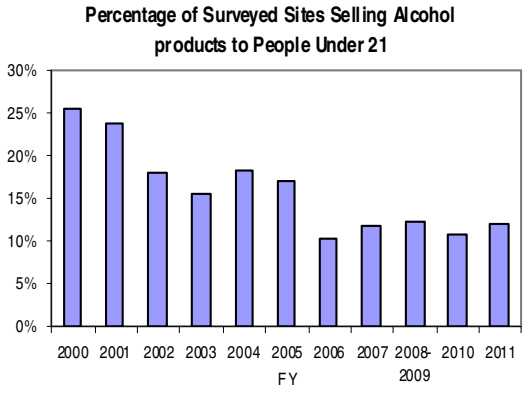
Substance abuse prevention and mental health promotion services are provided through contracts administered by DBH and managed across the Department. Prevention services are provided through: 35 contracts with municipalities funded through the Rhode Island Substance Abuse Prevention Act, three contracts for Student Assistance services in middle and high schools funded through the Substance Abuse Prevention and Treatment Block Grant (SAPT BG), nine contracts to implement an initiative to reduce and prevent marijuana and other illicit drug use among high school students funded through the SAPTBG, and one contract to manage and implement the Enforcing Underage Drinking Laws program funded by the federal Office of Juvenile Justice and Delinquency Prevention. Through these programs, residents of all of the state's 39 municipalities are exposed to public education and other strategies designed to change community norms, prevent alcohol and other drug use, reduce retail purchases of alcohol by children and youth, and arrest the progression from initial substance use to abuse and dependency.

Through SAPTBG and other federal funding, the Department collects, analyzes, and reports on community and state-level consumption patterns and consequences. BHDDH also conducts implementation and outcome evaluations of major initiatives and will be setting up a prevention resource center to provide training and technical assistance for prevention providers in order to support the implementation of evidence-based programming.

The Department also administers a program to reduce youth access to tobacco products. The State has consistently maintained a tobacco sales rate well below the national performance standard of 20 percent.



In addition, the department monitors the rate of retail alcohol sales to children and youth. Results indicate that there has been considerable success in reducing retail sales of alcohol to minors.



New Emphasis:

The Department continues to look at the best ways to improve our outcomes and spend our dollars appropriately. We are concentrating our efforts in the following areas:

Housing: Our work in this area began with our decision to re-direct our PATH funding to increase outreach for the Housing First Program. Through our Thresholds Program and by turning over our vacant property to community providers we have been able to create over 150 units of transitional or permanent housing. Some of these initiatives have focused on homeless veterans, families with disabled individuals, and women. Housing vouchers from our Access To Recovery (ATR) program have allowed a large number of people in recovery to move into new housing

Employment: We have also begun to focus on increasing employment opportunities and transforming some of our day activities into actual employment development programs for individuals with disabilities. This initiative follows an "employment first" model. In partnership with the Sherlock Center, we produced the first "Employment Survey" for individuals with disabilities to use as the foundation of our work. And, last year, the General Assembly approved our employment set-aside legislation. We have received two workforce development grants to assist us in this effort.

Recovery: Throughout our systems of care, we have re-focused on recovery principles as a way to improve the lives of individuals and to more effectively support people in avoiding relapse and hospitalizations. Many of the changes in mental health and substance abuse have been designed to support recovery. RI is one of the national leaders, at this time, in peer-supports as part of this effort.

Veterans and Re-entry: Two special populations that we have intensified our efforts around are veterans and individuals coming out of the criminal justice system. These efforts are part of our work on employment and housing. In addition, the Department implemented "Project Immersion" in conjunction with the RI National Guard; and our prisoner re-entry work resulted in our Director receiving the "Friend of the Department of Corrections" award this past year.

Parity and Health Care Reform: A major new focus over the next two years will be the true integration of behavioral healthcare into primary care and the achievement of meaningful parity. This work will be done in conjunction with the implementation of the Affordable care Act.

"Without a roof over ones head and a decent job, it is impossible for someone to reach and sustain their recovery."

Craig S. Stenning, Director

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